ARIZONA AIDS DRUG ASSISTANCE PROGRAM
ENFUVIRTIDE (ENF, FUZEON) APPLICATION

Client Name:_____ Date of Application:_____

General Indications

Previous therapy with at least 1 NRTI, 1 NNRTI and 1 PI, with at least 3 months duration of therapy with each class? ☐ Yes ☐ No

Please list prior antiretroviral agents. _____

_____

History of moderate to severe adverse events/intolerance to at least 1 NRTI, NNRTI and PI?
☐ Yes ☐ No

Documented viral resistance to at least one member each of the NRTI, NNRTI and PI class of antiretrovirals? ☐ Yes ☐ No

HIV RNA (viral load) >5000 after at least 3 months of combination antiretroviral therapy with evidence of adequate patient adherence? ☐ Yes ☐ No

*****Most recent viral load_____ Date obtained _____

*****Most recent CD4 count _____ Date obtained _____

***Please attach or fax most recent viral load and CD4 count lab reports.**

☐ Patient is not currently an injection drug user and has not used injection drugs for at least 6 months; patient is not actively abusing alcohol or other substances.

☐ Prescriber is well-experienced in the care of patients with HIV/AIDS (or be consulting with HIV/AIDS specialist) and has sufficient office/clinic capability to provide patient education and monitoring.

Patient/Caregiver

☐ Patient or caregiver is willing to administer or have administered ENF by subcutaneous injection twice daily; such willingness is confirmed after the injection site reactions associated with ENF are described by the prescriber or designee.

☐ Patient has prior evidence of adherence to therapy and other medical care; prescriber has reasonable expectation that adherent behavior will continue after the initiation of ENF therapy.

☐ Patient's home has sufficient heating and cooling to allow ENF storage at proper temperatures (59-86F).

HIV Resistance Testing (Please attach or send copy of most recent lab report)

Date of most recent resistance test _____ ☐ Genotypic ☐ Phenotypic

Virus susceptible to _____

_____

Virus resistant to _____

_____

Proposed ENF-containing antiretroviral regimen _____

_____

☐ Patient will have repeat HIV RNA and CD4 counts performed 12 and 24 weeks after initiation of ENF-containing regimen to assess effectiveness.

If this patient does not meet current ADAP guidelines for ENF use, please provide information regarding the medical necessity and justification for use_____

_____

Physician Signature_____

Please submit this form to the ADAP office by e-mail (krogerl@azdhs.gov) or fax (602-364-3263). If submitting electronically, please save the file as a unique, identifiable file name. Copies of resistance test reports may be faxed if electronic copies are not available. HIPAA regulations must be followed when transmitting documents with patient-identifying information. If you have any questions, please call 602-364-3594.

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